		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034975

Facility Name: Our Lady of Angels Retirement Home

Address: 1201 Wyoming Ave (Number) Joliet (City) 60435 (Zip Code)

County: Will

Telephone Number: 815/ 725-6631 **Fax #** 815/ 715-1451

IDPA ID Number: 36-2486076

Date of Initial License for Current Owners: 08/10/1962

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Lisa McClanahan **Telephone Number:** (815) 725-6631

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Stephen McMillin
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward R. Marso, C.P.A., Partner
(Firm Name & Address) Wermer, Rogers, Doran & Ruzon, LLC
755 Essington Road, Joliet, IL 60435
(Telephone) (815) 730-6250 Fax # (815) 730-6257

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5	50	Sheltered Care (SC)	50	18,250	5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	5,854	12,015		17,869	10
11	ICF/DD					11
12	SC		14,661		14,661	12
13	DD 16 OR LESS					13
14	TOTALS	5,854	26,676		32,530	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.12%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/10/62

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	448,504	29,572		478,076	11,611	489,687	(230,704)	258,983			1
2	Food Purchase		398,189		398,189		398,189	(187,597)	210,592			2
3	Housekeeping	182,845	64,390		247,235		247,235	(129,487)	117,748			3
4	Laundry	89,650	284		89,934		89,934	(40,712)	49,222			4
5	Heat and Other Utilities			222,045	222,045		222,045	(114,074)	107,971			5
6	Maintenance	227,331	113,967	9,001	350,299		350,299	(179,963)	170,336			6
7	Other (specify):*											7
8	**TOTAL General Services**	948,330	606,402	231,046	1,785,778	11,611	1,797,389	(882,537)	914,852			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,916,234	39,755		1,955,989	11,021	1,967,010	(922,865)	1,044,145			10
10a	Therapy	49,564			49,564		49,564		49,564			10a
11	Activities	99,945		38,708	138,653	133,910	272,563		272,563			11
12	Social Services	8,529		6,502	15,031	2,626	17,657		17,657			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,074,272	39,755	45,210	2,159,237	147,557	2,306,794	(922,865)	1,383,929			16
	C. General Administration											
17	Administrative	40,119		16,053	56,172	70,000	126,172	(59,443)	66,729			17
18	Directors Fees											18
19	Professional Services			153,488	153,488		153,488	(72,312)	81,176			19
20	Dues, Fees, Subscriptions & Promotions			16,642	16,642		16,642	(7,840)	8,802			20
21	Clerical & General Office Expenses	311,861	16,238		328,099	(67,353)	260,746	(122,844)	137,902			21
22	Employee Benefits & Payroll Taxes			607,891	607,891		607,891	(286,393)	321,498			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,784	15,784		15,784	(7,436)	8,348			24
25	Other Admin. Staff Transportation			8,250	8,250		8,250	(3,887)	4,363			25
26	Insurance-Prop.Liab.Malpractice			109,791	109,791		109,791	(51,725)	58,066			26
27	Other (specify):*			30,661	30,661		30,661	(29,301)	1,360			27
28	**TOTAL General Administration**	351,980	16,238	958,560	1,326,778	2,647	1,329,425	(641,181)	688,244			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,374,582	662,395	1,234,816	5,271,793	161,815	5,433,608	(2,446,583)	2,987,025			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Our Lady of Angels Retirement Home #0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			185,891	185,891		185,891	(4,526)	181,365			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31	31		31		31			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			828,000	828,000		828,000	(390,092)	437,908			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,013,922	1,013,922		1,013,922	(394,618)	619,304			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	8,249	4,272		12,521	2,282	14,803		14,803			41
42	Provider Participation Fee			27,450	27,450		27,450		27,450			42
43	Other (specify):*	195,042	23,577		218,619	(164,097)	54,522	(54,522)				43
44	**TOTAL Special Cost Centers**	203,291	27,849	27,450	258,590	(161,815)	96,775	(54,522)	42,253			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,577,873	690,244	2,276,188	6,544,305		6,544,305	(2,895,723)	3,648,582			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,526)	30		9
10	Interest and Other Investment Income	(830)	27		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(230,704)	1		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,159)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,532,385)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,795,704)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,795,704)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Our Lady of Angels Retirement Home

ID# 0034975

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chapel Costs	$ (34,748)	43	1
2	OLA Fest	(14,562)	43	2
3	Other Fundraising	(5,212)	43	3
4				4
5	Allocation of Religious Order Costs	(187,597)	2	5
6		(129,487)	3	6
7		(40,712)	4	7
8		(114,074)	5	8
9		(179,963)	6	9
10		(922,865)	10	10
11		(59,443)	17	11
12		(72,312)	19	12
13		(7,840)	20	13
14		(122,844)	21	14
15		(286,393)	22	15
16		(7,436)	24	16
17		(3,887)	25	17
18		(51,725)	26	18
19		(1,212)	27	19
20		(390,092)	34	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,632,404)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(230,704)	0	0	0	0	0	0	0	0	0	0	(230,704)	1
2	Food Purchase	(187,597)	0	0	0	0	0	0	0	0	0	0	(187,597)	2
3	Housekeeping	(129,487)	0	0	0	0	0	0	0	0	0	0	(129,487)	3
4	Laundry	(40,712)	0	0	0	0	0	0	0	0	0	0	(40,712)	4
5	Heat and Other Utilities	(114,074)	0	0	0	0	0	0	0	0	0	0	(114,074)	5
6	Maintenance	(179,963)	0	0	0	0	0	0	0	0	0	0	(179,963)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(882,537)	0	0	0	0	0	0	0	0	0	0	(882,537)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(922,865)	0	0	0	0	0	0	0	0	0	0	(922,865)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(922,865)	0	0	0	0	0	0	0	0	0	0	(922,865)	16
	C. General Administration													
17	Administrative	(59,443)	0	0	0	0	0	0	0	0	0	0	(59,443)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(72,312)	0	0	0	0	0	0	0	0	0	0	(72,312)	19
20	Fees, Subscriptions & Promotions	(7,840)	0	0	0	0	0	0	0	0	0	0	(7,840)	20
21	Clerical & General Office Expenses	(122,844)	0	0	0	0	0	0	0	0	0	0	(122,844)	21
22	Employee Benefits & Payroll Taxes	(286,393)	0	0	0	0	0	0	0	0	0	0	(286,393)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,436)	0	0	0	0	0	0	0	0	0	0	(7,436)	24
25	Other Admin. Staff Transportation	(3,887)	0	0	0	0	0	0	0	0	0	0	(3,887)	25
26	Insurance-Prop.Liab.Malpractice	(51,725)	0	0	0	0	0	0	0	0	0	0	(51,725)	26
27	Other (specify):*	(29,301)	0	0	0	0	0	0	0	0	0	0	(29,301)	27
28	**TOTAL General Administration**	(641,181)	0	0	0	0	0	0	0	0	0	0	(641,181)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,446,583)	0	0	0	0	0	0	0	0	0	0	(2,446,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(4,526)	0	0	0	0	0	0	0	0	0	0	(4,526)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(390,092)	0	0	0	0	0	0	0	0	0	0	(390,092)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(394,618)	0	0	0	0	0	0	0	0	0	0	(394,618)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(54,522)	0	0	0	0	0	0	0	0	0	0	(54,522)	43
44	**TOTAL Special Cost Centers**	(54,522)	0	0	0	0	0	0	0	0	0	0	(54,522)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,895,723)	0	0	0	0	0	0	0	0	0	0	(2,895,723)	45

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sisters of St. Francis	100	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Rent	$ 828,000	Sisters of St. Francis	100.00%	$ 828,000	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 828,000			$ 828,000	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Owned by religious order (Total compensation $ 185,494 - listed those over $20,000)									43-1	2
3											3
4	Sr. Lucille Adelmann		Chaplain	0.00	0	40	100.00	Wage	21,397	43-6	4
5	Sr. Odelia Kloc		Activities	0.00	0	40	100.00	Wage	29,812	11-5	5
6	Sr. Elaine Murphy		Admission Direct	0.00	0	40	100.00	Wage	31,406	21-5	6
7	Sr. Mary Gen Wolffram		Activity Director	0.00	0	40	100.00	Wage	31,406	11-5	7
8											8
9	Others under $20,000								71,473		9
10											10
11											11
12											12
13								TOTAL	$ 185,494		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	GMAC		X	Vehicle Purchase	$325.73	01/15/02			08/05/03	3.9000	31	6
7												7
8												8
9	**TOTAL Facility Related**				$325.73		$	$			$ 31	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$ 31	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Our Lady of Angels Retirement Hom COUNTY Will

FACILITY IDPH LICENSE NUMBER 0034975

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,326 B. General Construction Type: Exterior Class C Frame Steel & Brick Number of Stories Two

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	609,840	1962	$	1
2					2
3	TOTALS	609,840		$	3

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Ceiling Painting			1991	39,535	989	40	989		13,344	9
10	North Parking Lot			1991	40,366	1,009	40	1,009		13,623	10
11	2 Air Conditioning Units			1992	22,403	560	40	560		7,001	11
12	Call System			1992	13,400	335	40	335		4,188	12
13	Television Antenna			1992	778	19	40	19		243	13
14	Elevator Door Motor			1992	820	21	40	21		257	14
15	Garage			1992	9,958	249	40	249		3,112	15
16	Fence For Compactor			1992	888	22	40	22		277	16
17	Cabinets & Counter Tops			1992	2,700	68	40	68		844	17
18	Sidewalk			1992	10,038	251	40	251		3,137	18
19	Multi Purpose Room			1993	11,531	288	40	288		3,318	19
20	Nurse Call Light System			1993	28,765	719	40	719		8,270	20
21	Doors			1993	32,652	816	40	816		9,387	21
22	Reseal Roadway			1993	10,845	271	40	271		3,118	22
23	Cooling Tower			1993	51,950	1,299	40	1,299		14,936	23
24	Miscellaneous			1993	8,542	214	40	214		2,456	24
25	Air Conditioner			1993	5,878	147	40	147		1,690	25
26	Room Numbers			1994	11,307	283	40	283		2,968	26
27	Miscellaneous			1994	33,085	827	40	827		8,685	27
28	Master Clocks			1994	5,655	141	40	141		1,484	28
29	Floresent Lights			1994	7,619	190	40	190		1,999	29
30	Lot C - Wall & Door			1994	1,549	39	40	39		407	30
31	Library - Wall & Door			1994	1,574	40	40	40		414	31
32	Doors			1994	18,079	452	40	452		4,746	32
33	Air Conditioner			1995	4,000	100	40	100		950	33
34	Fire Door Closures			1995	6,379	159	40	159		1,515	34
35	Fire Door Closures			1995	2,300	58	40	58		547	35
36	New Burners For Boiler			1995	18,279	457	40	457		4,341	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remodel Admissions Office	1995	$ 2,371	$ 59	40	$ 59	$	$ 563	37
38	Gas Lines	1995	562	14	40	14		133	38
39	Relocate Duane Controls	1995	1,460	37	40	37		347	39
40	Remodel Lobby	1995	1,455	36	40	36		345	40
41	Doors	1995	35,236	881	40	881		8,369	41
42	Telephone System	1995	17,881	447	40	447		4,247	42
43	Doors	1995	6,207	155	40	155		1,474	43
44	Boiler Room	1995	1,559	39	40	39		370	44
45	Remodel Kitchenette	1995	1,830	46	40	46		435	45
46	Laundry Room Lighting	1995	975	24	40	24		231	46
47	Elevator Sensing Edges	1995	5,500	138	40	138		1,307	47
48	Sinks	1995	20,932	523	40	523		4,971	48
49	Miscellaneous	1995	79,482	1,987	40	1,987		18,877	49
50	Windows	1996	167,206	4,180	40	4,180		35,531	50
51	Miscellaneous	1996	21,030	526	40	526		4,469	51
52	Chain Link Fence	1997	6,536	163	40	163		1,228	52
53	Asbestos Abatement - Boiler Room	1997	98,023	2,451	40	2,451		18,418	53
54	Windows	1997	113,787	2,845	40	2,845		21,380	54
55	Kitchen Ceiling	1997	16,708	418	40	418		3,140	55
56	Roof Replacement D-1	1997	200,052	5,001	40	5,001		37,587	56
57	Remodel D-1	1997	268,439	6,711	40	6,711		50,437	57
58	Air Conditioner Compressor	1998	3,445	86	40	86		560	58
59	Kitchen Renovation	1998	9,600	240	40	240		1,560	59
60	Chapel Sound System	1998	5,233	131	40	131		851	60
61	Chapel Pews	1998	5,544	138	40	138		900	61
62	Roof/ Skylight Replacement	1998	218,548	5,464	40	5,464		35,514	62
63	Chapel Roof	1999	5,332	133	40	133		733	63
64	Garage Heater	2000	43,625	1,091	40	1,091		4,908	64
65	Garage Doors	2000	4,553	114	40	114		512	65
66	Garage Wiring	2000	9,685	242	40	242		1,089	66
67	New Ceiling	2000	43,737	1,093	40	1,093		4,920	67
68	Side Altar	2000	5,400	135	40	135		608	68
69	Remodel 2 Restrooms	2000	16,450	411	40	411		1,851	69
70	TOTAL (lines 4 thru 69)		$ 1,839,258	$ 45,982		$ 45,982	$	$ 385,122	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,839,258	$ 45,982		$ 45,982	$	$ 385,122	1
2	Remodel Public Restrooms	2001	28,982	725	40	725		2,487	2
3	Remodel Chaplain's Kitchen	2001	3,730	93	40	93		279	3
4	Remodel 5 Bathrooms	2001	21,864	1,093	20	1,093		3,004	4
5	Remodel 6 Bathrooms	2002	24,410	1,220	20	1,220		2,853	5
6	Remodel - C Wing	2002	26,325	1,316	20	1,316		2,742	6
7	Remodel - C Wing	2003	71,961	3,598	20	3,598		5,535	7
8	Remodel - D Wing	2003	348,181	17,409	20	17,409		28,139	8
9	Landscape Garden Walk	2003	11,500	575	20	575		575	9
10	Remodel 6 Bathrooms	2004	26,400	110	20	110		110	10
11	Closed Circuit TV System	2004	19,900		20				11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,422,511	$ 72,121		$ 72,121	$	$ 430,846	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 668,973	$ 91,112	$ 91,112	$	5-15	$ 306,587	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	74,349					74,349	73
74								74
75	TOTALS	$ 743,322	$ 91,112	$ 91,112	$		$ 380,936	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Ford Taurus Wagon	1997	$ 18,186	$	$	$	5	$ 18,186	76
77	Patient Care	1999 Freedom Van	1999	35,909	7,182	7,182		5	32,318	77
78	Patient Care	2002 Glaval 14 Passenger Van	2002	54,750	10,950	10,950		5	27,375	78
79										79
80	TOTALS			$ 108,845	$ 18,132	$ 18,132	$		$ 77,879	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,274,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,365	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,365	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 889,661	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 John Deere Tractor	$ 11,000	$ 2,200	$ 9,900	86
87	1998 Chev P/U Truck	26,820		26,820	87
88	2001 Buick Century (Sold)		2,326		88
89					89
90					90
91	TOTALS	$ 37,820	$ 4,526	$ 36,720	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Our Lady of Angels Retirement Home

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1962	100	07/01/2000	$ 828,000	9		3
4	Additions							4
5								5
6								6
7	TOTAL		100		$ 828,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/2000
Ending 07/01/2009

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2005	$ 840,420
13.	6/30/2006	$ 853,020
14.	6/30/2007	$ 865,800

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 284,887	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	89,273		3
4	Supply Inventory (priced at Cost)	7,927		4
5	Short-Term Investments	563,415		5
6	Prepaid Insurance	19,985		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	18,067		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 983,554	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,527,079		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,422,511		15
16	Equipment, at Historical Cost	889,987		16
17	Accumulated Depreciation (book methods)	(926,381)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,913,196	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,896,750	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 113,212	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	254,296		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,362		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 371,870	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,630		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 78,630	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 450,500	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,446,250	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,896,750	$	48

***(See instructions.)**

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,534,591	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,534,591	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(88,341)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (88,341)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,446,250	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,180,070	1
2	Discounts and Allowances for all Levels	(110,932)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,069,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	23,930	12
13	Barber and Beauty Care	1,795	13
14	Non-Patient Meals	331	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,550	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	46,582	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 77,188	23
	D. Non-Operating Revenue		
24	Contributions	176,301	24
25	Interest and Other Investment Income***	62,069	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 238,370	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	6,755	28
28a	OLA Fest & Other Fund Raising	64,513	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 71,268	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,455,964	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,785,778	31
32	Health Care	2,159,237	32
33	General Administration	1,326,778	33
	B. Capital Expense		
34	Ownership	1,013,922	34
	C. Ancillary Expense		
35	Special Cost Centers	12,521	35
36	Provider Participation Fee	27,450	36
	D. Other Expenses (specify):		
37	Chapel & Fund Raising	23,577	37
38	Religious Personnel Wages	195,042	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,544,305	40
41	**Income before Income Taxes (line 30 minus line 40)****	(88,341)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (88,341)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,677	2,080	$ 47,891	$ 23.02	1
2	Assistant Director of Nursing	1,860	2,080	49,760	23.92	2
3	Registered Nurses	17,339	18,035	414,583	22.99	3
4	Licensed Practical Nurses	28,785	30,031	556,287	18.52	4
5	Nurse Aides & Orderlies	81,476	83,956	870,960	10.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,699	3,699	49,564	13.40	8
9	Activity Director	1,882	2,080	33,123	15.92	9
10	Activity Assistants	12,857	13,256	139,165	10.50	10
11	Social Service Workers	3,018	3,250	51,135	15.73	11
12	Dietician	2,032	2,112	20,851	9.87	12
13	Food Service Supervisor	7,010	7,510	109,999	14.65	13
14	Head Cook	10,115	10,595	116,139	10.96	14
15	Cook Helpers/Assistants	19,483	19,923	152,417	7.65	15
16	Dishwashers	6,827	6,947	49,719	7.16	16
17	Maintenance Workers	14,150	14,710	227,331	15.45	17
18	Housekeepers	23,497	24,706	182,845	7.40	18
19	Laundry	9,616	9,976	89,650	8.99	19
20	Administrator	2,080	2,080	70,000	33.65	20
21	Assistant Administrator	1,360	1,360	35,808	26.33	21
22	Other Administrative	4,787	6,240	115,467	18.50	22
23	Office Manager	2,031	2,211	42,326	19.14	23
24	Clerical	9,866	10,410	95,362	9.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,707	1,707	14,722	8.62	31
32	Other Health Care(specify)					32
33	Other(specify)	4,368	4,471	42,769	9.57	33
34	TOTAL (lines 1 - 33)	271,522	283,425	$ 3,577,873 *	$ 12.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Craig Tuntland	Develop Dir		40,119
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 40,119

B. Administrative - Other

Description	Amount
	$
Telephone & Other Admin Costs	16,053
TOTAL (agree to Schedule V, line 17, col. 3)	$ 16,053
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Office Team	Temporary Office Help	$ 8,428
ADP	Data Processing Fees	17,647
Keane Care	Computer Programming	14,878
Spesia, Ayers & Ardaugh	Legal Fees	6,930
Tracy, Johnson & Wilson	Prep IL Annual Report	83
George Bagley & Company	Accounting	13,426
Wermer Rogers Doran & Ruzon	Accounting	21,466
Jackson Lewis	Legal Fees	21,618
BDO Siedman	Consulting	4,500
Comprehensive Therapy	Consulting	1,904
HCMA	Consulting	25,956
Other Consultants	Consulting	16,652
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 153,488

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,699
Unemployment Compensation Insurance	24,148
FICA Taxes	256,900
Employee Health Insurance	168,784
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension	67,360
Allocated To Care Of Sisters	(286,393)
TOTAL (agree to Schedule V, line 22, col.8)	$ 321,498

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Books & Subscriptions	3,144
Dues	8,291
Licenses	5,207
Allocated To Care Of Sisters	(7,840)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,802

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Reimbursed	(57)
Seminar Expense	11,052
New Employee Training	4,789
Allocated To Care Of Sisters	(7,436)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,348

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Our Lady of Angels Retirement Home # 0034975 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Our Lady of Angels Retirement Home **#** 0034975 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,542** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **27,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Page 3, Schedule V, Line 27

	3, 4 & 6	Column 7	8
Advertising	12,900	(12,900)	-
Donations	100	(100)	-
Investment Expenses	830	(830)	-
Miscellaneous	2,572	(1,212)	1,360
Public Relations	14,259	(14,259)	-
Total	30,661	(29,301)	1,360

Page 4, Schedule V, Line 43

	1	2	4	5	6	7
Wages To Religious (Reclass all except Chapel)	195,042	-	195,042	(164,097)	30,945	(30,945)
Chapel Costs	-	3,803	3,803	-	3,803	(3,803)
OLA Fest	-	14,562	14,562	-	14,562	(14,562)
Other Fund Raising	-	5,212	5,212	-	5,212	(5,212)
Total	195,042	23,577	218,619	(164,097)	54,522	(54,522)